PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.b. Rural health clinic (RHC) services and other ambulatory services furnished by a rural health clinic. Subparagraph (1) through (5) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

(1) Effective for dates of service occurring January 1, 2001 and after, RHCs are reimbursed on a prospective payment rate. The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the clinic's fiscal years 1999 and 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the RHC (calculating the payment amount on a per visit basis).

(A) In determining the initial PPS rate, cost caps for core services shall continue to be used to determine reasonable cost, as established by Medicare.

(B) The clinic's average fiscal years 1999 and 2000 cost shall be calculated by adding the total reasonable costs together for fiscal year 1999 and fiscal year 2000 and dividing by the number of visits.

(C) A visit means a face-to-face encounter between an RHC patient and any health professional whose services are reimbursed under the State Plan.

(D) In the case of any RHC participating with a licensed Medicaid managed care organization, and receiving either PPS or cost based reimbursement, quarterly reconciliation will occur with supplemental payments made no less frequently than every four months to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system. A final annual reconciliation of any supplemental payments will be completed at the end of the RHCs' fiscal year upon determination of the final cost based or PPS rate for the period.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(2) At the beginning of each clinic's fiscal year, subsequent to January 1, 2001, the rates shall be increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year.

(A) A rate adjustment due to change in the scope of services must be supported by the preponderance of evidence by the provider.

(B) The Division of Medical Assistance shall make rate adjustments due to change in the scope of services.

(C) The MEI rate adjustment shall take effect on the first day of the provider's fiscal year.

(D) Rates may also be adjusted to take into consideration reasonable changes in the industry's cost of service.

(3) Newly qualified RHCs after December 31, 2000, will have their initial rates established either by reference to rates paid to other clinics in the same or adjacent areas with similar caseload, or in the absence of such other clinics, through cost reporting methods. Rates for subsequent fiscal years shall be based on the same update methods reflected in subparagraph (2) above.

Alternative Payments

(4) Providers who elected to be reimbursed in accordance to the cost based methodology in effect on December 31, 2000, and who did not change their election prior to January 1, 2005 shall remain with that choice of cost based reimbursement methodology.

(A) Rates paid under this cost based reimbursement methodology must be at least equal to the payment under the payment methodology included in subparagraphs (1) and (2). To ensure providers receive no less under the cost based reimbursement methodology than under PPS, the actual amount received under cost based reimbursement is compared to the amount a provider would have received under PPS.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(B) Provider clinics are paid on the basis of the principles and at the Medicare determined rates specified in the Medicare regulation in Part 405, Subpart D not to exceed the Medicare established limits. For Medicaid only services, the interim rates are based on a Medicaid fee schedule.

(C) Independent clinics are paid for all core services offered by the clinic at a single cost-reimbursement rate for clinic visit, established by the Medicare carrier, which includes the cost of all core services furnished by the clinic.

(D) Effective October 1, 1993, physician-provided services at a hospital inpatient or an outpatient location are paid at the existing fee-for-service rate only to those clinics whose agreement with their physician states that the clinic does not compensate the physician for services in a location other than at the rural health clinic location.

(E) If the Core Service Provider Number has a Change of Ownership, the new provider will be reimbursed under the PPS methodology established in paragraph (3) above.

Enhanced Reimbursement for Pregnancy Medical Home Services will be made to RHC providers as specified in Attachment 3.1-B, Page 7(a) and Attachment 3.1-F. The Pregnancy Medical Home will be paid these enhanced payments in additional to their regular reimbursement.

Two enhanced payments may be made to RHCs for services provided by a Pregnancy Medical Home. Upon completion of the high risk screening, an enhanced payment of $50.00 will be made to the PMH. Upon completion of the recipient's post partum visit, an enhanced payment of $150.00 will be made to the PMH provider. The PMH provider will receive a maximum of $200 enhanced payments per recipient per pregnancy even if there are multiple births.

Additionally, the PMH provider receives an enhanced rate for a vaginal delivery by paying the same rate for the vaginal delivery as for an uncomplicated c-section. Only the physician rates for the delivery codes are enhanced. The enhanced rates were determined by applying a 13.2% increase to the NC Medicaid Physician Fee Schedule rate as established in Attachment 4.19-B Section 5, Page 1 of the State Plan.

There shall be no cost settlement for any provider in any setting for these services reimbursed at the enhanced rates.

Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 3, Page 1 of the State Plan.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.c. Federally qualified health center (FQHC) services and other ambulatory services furnished by a federally qualified health center. Subparagraph (1) through (5) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

(1) Effective for dates of service occurring January 1, 2001 and after, FQHCs are reimbursed on a prospective payment rate. The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the center's fiscal years 1999 and 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the FQHC (calculating the payment amount on a per visit basis).

(A) In determining the initial PPS rate, cost caps for core services shall continue to be used to determine reasonable cost, as established by Medicare.

(B) The center's average fiscal years 1999 and 2000 cost shall be calculated by adding the total reasonable costs together for fiscal year 1999 and fiscal year 2000 and dividing by the number of visits.

(C) A visit means a face-to-face encounter between an FQHC patient and any health professional whose services are reimbursed under the State Plan.

(D) In the case of any FQHC participating with a licensed Medicaid managed care organization and receiving either PPS or cost based reimbursement, quarterly reconciliation will occur with supplemental payments made no less frequently than every four months to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system. A final annual reconciliation of any supplemental payments will be completed at the end of the FQHCs' fiscal year upon determination of the final cost based or PPS rate for the period.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(2) At the beginning of each center's fiscal year, subsequent to January 1, 2001, the rates shall be increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year.

(A) A rate adjustment due to change in the scope of services must be supported by the preponderance of evidence by the provider.

(B) The Division of Medical Assistance shall make rate adjustments due to change in the scope of services.

(C) The MEI rate adjustment shall take effect on the first day of the provider's fiscal year.

(D) Rates may also be adjusted to take into consideration reasonable changes in the industry's cost of service.

(3) Newly qualified FQHCs after December 31, 2000, will have their initial rates established either by reference to rates paid to other centers in the same or adjacent areas with similar caseload, or in the absence of such other centers, through cost reporting methods. Rates for subsequent fiscal years shall be based on the same update methods reflected in subparagraph (2) above.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

Alternative Payments

(4) Providers who elected to be reimbursed in accordance to the cost based methodology in effect on December 31, 2000, and who did not change their election prior to January 1, 2005 shall remain with that choice of cost based reimbursement methodology.

(A) Rates paid under this cost based reimbursement methodology must be at least equal to the payment under the payment methodology included in subparagraphs (1) and (2). To ensure providers receive no less under the cost based reimbursement methodology than under PPS, the actual amount received under cost based reimbursement is compared to the amount a provider would have received under PPS.

(B) Services furnished by a federally qualified health center (FQHC) are reimbursed at one hundred percent (100%) of reasonable cost, not to exceed the Medicare established limits, as determined in an annual cost report, based on Medicare principles and methods (for Medicaid only services, the interim rates are based on a Medicaid fee schedule) when:

(1) It is receiving a grant under Section 329 (migrant health centers), 330 (community health centers) or 340 (health care centers for the homeless), Public Housing Health Centers receiving grant funds under Section 340A of the Public Health Service Act and Urban Indian organizations receiving funds under Title V of the Indian Health Improvement Act are FQHC's effective calendar quarter beginning or after October 1, 1993;

(2) It meets the requirements for receiving a Public Health Service grant or was treated as a comprehensive federally funded health center as of January 1, 1990.

(3) Nutrition services are provided by RHC's and FQHC. Providers are reimbursed in accordance with reimbursement methodologies established for services provided by RHC's and FQHCs as based on Medicare principles.

(4) Effective October 1, 1993, physician-provided services at a hospital inpatient and an outpatient location are paid at the existing fee-for-service rate only to those clinics whose agreement with their physician states that the clinic does not compensate the physician for services in a location other than at the federally qualified health clinic location.

(C) If the Core Service Provider Number has a Change of Ownership, the new provider will be reimbursed under the PPS methodology established in paragraph (3) above.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

Alternative Payments

Enhanced Payments for Pregnancy Medical Home Services will be made to FQHC providers as specified in Attachment 3.1-B, Page 7(a) and Attachment 3.1-F. The Pregnancy Medical Home will be paid these enhanced payments in additional to their regular reimbursement.

(5) Two enhanced payments may be made to FQHCs for services provided by a Pregnancy Medical Home. Upon completion of the high risk screening, an enhanced payment of $50.00 will be made to the PMH. Upon completion of the recipient's post partum visit, an enhanced payment of $150.00 will be made to the PMH provider. The PMH provider will receive a maximum of $200 enhanced payments per recipient per pregnancy even if there are multiple births.

Additionally, the PMH provider receives an enhanced rate for a vaginal delivery by paying the same rate for the vaginal delivery as for an uncomplicated c-section. Only the physician rates for the delivery codes are enhanced. The enhanced rates were determined by applying a 13.2% increase to the NC Medicaid Physician Fee Schedule rate as established in Attachment 4.19-B Section 5, Page 1 of the State Plan.

There shall be no cost settlement for any provider in any setting for these services reimbursed at the enhanced rates.

Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 3, Page 1 of the State Plan.